STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		(X2) MULTIPLE CO A. BUILDING B. WING STREET A	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 06/17/2011			
	PROVIDER OR SUPPLIEF HEALTH & REHAE		170 N TRACY ST MARKLE, IN46770				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
F0000							
	This visit was fo	r a Recertification and	F0000				
	State Licensure						
	State Elections i	3th vey					
	Survey dates: June 13, 14, 15, 16, and 17, 2011						
	Facility number:	000544					
	Provider number						
	AIM number: 10	0026/340					
	and 17, 2011)	N-TC (June 13, 15, 16, N (June 13, 15, 16, and					
	Census bed type						
	SNF/NF: 66	•					
	Total: 66						
	101a1. 00						
	Census payor typ Medicare: 5 Medicaid: 43 Other: 18 Total: 66	pe:					
	Sample: 15 Supplemental sa						
		es reflect state findings nee with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

YIQU11

Facility ID:

000544

TITLE

If continuation sheet

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155673	B. WING		06/17/2011
NAME OF E	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF F	ROVIDER OR SUPPLIER		170 N 7	TRACY ST	
MARKLE	HEALTH & REHAE	BILITATION	MARKL	LE, IN46770	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		ompleted 6/24/11 by			
	Jennie Bartelt, R	N.			
F0223	The resident has t	he right to be free from			
SS=A		ysical, and mental abuse,			
	corporal punishment, and involuntary				
	seclusion.				
	•	ot use verbal, mental,			
	sexual, or physica	l abuse, corporal voluntary seclusion.			
	= -	ew and record review, the	F0223	F223- Abuse- Staff Treatme	nt of 07/17/2011
		prevent staff from using		ResidentsIt is the practice of	f this
		age about a resident		provider that all residents mu not be subjected to abuse by	l l
	(Resident #52) w	rithin hearing distance of		anyone, including, but not lir	
	the resident for 1	of 3 residents reviewed		to, facility staff, other resider	
	for abuse in a sup	oplemental sample of 3.		consultants or volunteers, st	
	Findings include	:		resident, family members or guardians, friends or other individuals. It is also the prac	
	Resident # 52's re	ecord was reviewed on		of this provider that each res	sident
	6/17/11 at 9:15 a	.m. The record indicated		has the right to be free from mistreatment, neglect and	
	diagnoses includ	ed, but were not limited		misappropriation of funds. I.	What
	· · · · · · · · · · · · · · · · · · ·	hypertension, dementia		corrective action(s) will be	
	*	nd dementia with		accomplished for those reside found to have been affected	
	behavioral symp	toms.		the deficient practice?Reside	ent
	On 2/18/11 Phys	ical Therapy Assistant		physical or emotional outcor	
	was overheard, b	y the Administrator,		a result of this finding. The	a din a
	telling a certified	nursing assistant that		employee identified in this fir	naing

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	l DIII	, DDIG	00	COMPL	ETED
		155673	- 1	LDING		06/17/2	011
		1	B. WIN		ADDRESS STEV STATE STR CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	TRACY ST		
MARKLE	E HEALTH & REHAI	BILITATION		MARKL	.E, IN46770		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
	Resident #24 sm	nelled of "s"			is no longer employed at this		
					facility. II. How will you ident other residents having the	lily	
	The PTA was su	spended immediately,			potential to be affected by the	10	
	pending investigation and terminated on				same deficient practice and		
	2/22/11, as per f				corrective action will be take		
	2/22/11, as per 1	active policy.			residents are at risk to be	,,,,,,,,,	
					affected by this finding.Any		
		s observed for any			allegation or statement rega	rding	
	psychosocial dis	tress with no signs or			resident abuse or mistreatm		
	symptoms of dis	stress per social service			will be reported immediately		
	notes dated 3/1/	11.			the Administrator and DNS.		
					facility will immediately initia	te a	
	The incident we	a mamamtad ta ICDII			full investigation as well as		
		s reported to ISDH			ensure notification to the MI		
	`	epartment of Health) and			family, ISDH, and other age		
	other various ag	encies on 2/18/11 with the			as outlined in the facility poli		
	follow-up report	ted on 2/22/11 per ISDH			Appropriate disciplinary action including suspension and	OH	
		facility protocol.			possible termination of		
		F			employment will be a		
	T1 A 1				consideration for any staff		
		or was interviewed on			member involved in a		
		a.m. to review the abuse			substantiated allegation of a	buse	
	policies and pro-	cedures. She indicated			toward a resident. III. What		
	the employee ha	d been terminated			measures will be put into pla	ace or	
	according to the				what systemic changes will		
		· V · · · · V ·			made to ensure that the def		
	3.1-27(b)				practice does not recur?An		
	3.1-27(0)				staff in-service will be held b	у	
					7/15/2011 & conducted by		
					DNS/designee. This in-servi will include review of the fac		
					policy and procedure regard	•	
					Abuse Prohibition, Reporting		
					Investigation. Any allegation	•	
					statement regarding residen		
					abuse or mistreatment will b		
					reported immediately to the		
					Administrator and DNS. The)	
					facility will immediately initia	te a	
					full investigation as well as		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155673	B. WING		06/17/2011
	PROVIDER OR SUPPLIER		170 1	T ADDRESS, CITY, STATE, ZIP CODE N TRACY ST KLE, IN46770	
				100770	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
F0224 SS=A	The facility must d written policies and mistreatment, negrand misappropriate Based on intervier facility failed to president (Resident who was left und an extended period of the findings included Resident # 24's concerviewed on 6/17 record indicated were not limited congestive heart	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. ew and record review, the prevent neglect for 1 of 1 at # 24) in a sample of 15 attended on the toilet for od of time.	F0224	ensure notification to the ME family, ISDH, and other ager as outlined in the facility poli How will the corrective action be monitored to ensure the deficient practice will not reci.e. what Quality Assurance Program will be put into place?The DNS or other designee will be responsible completion of the CQI Audit titled, "Abuse Prohibition and Investigation" and "Abuse" w X4, monthly X3, and then quarterly thereafter to monito ongoing compliance. Any treor findings will be submitted CQI Committee for review at follow-up. Compliance Date: 7-17-11 F224- Abuse- Staff Treatmet ResidentsIt is the practice of provider that all residents munot be subjected to abuse by anyone, including, but not lir to, facility staff, other resider consultants or volunteers, stother agencies serving the resident, family members or guardians, friends or other individuals. It is also the practice of this provider that each resident that each resident to be free from mistreatment, neglect and misappropriation of funds. It corrective action(s) will be accomplished for those resident to have been affected.	oncies cy.IV. n(s) et for Tool do veekly or for ends to the nd end end end end end end end end end

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155673	B. WIN			06/17/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1	RACY ST		
MARKLE	E HEALTH & REHA	RII ITATION		1	E, IN46770		
					, 114-10770		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG	,		DATE
	disease, severe d	lementia and depression.			the deficient practice?Reside		
					#24 experienced no negative physical or emotional outcon		
	On 5/26/11 CNA	A #3 was asked by the			a result of this finding. The	ie as	
	nurse to toilet Resident #24 at				employee identified in this fir	ndina	
	approximately 11:25 a.m. The CNA				is no longer employed at this		
	assisted the resident to the toilet, placed				facility. II. How will you identi		
		ould sound if he attempted			other residents having the		
		•			potential to be affected by th		
		ne toilet and then left him			same deficient practice and		
		g on the toilet. The			corrective action will be take	n?All	
	resident was fou	nd sitting on the toilet at			residents are at risk to be affected by this finding.Any		
	approximately 12:15 P.M. by another				allegation or statement regar	dina	
	CNA.				resident abuse or mistreatme		
					will be reported immediately		
	The resident's sk	in was assessed with no			the Administrator and DNS.		
		the resident was			facility will immediately initiat	e a	
					full investigation as well as		
	_	sychosocial distress. The			ensure notification to the MD		
		nemory of the incident			family, ISDH, and other ager		
	1 ~	report dated 5/27/11 and			as outlined in the facility police Appropriate disciplinary action	-	
	signed by the Di	rector of Nursing			including suspension and	,,,	
	Services.				possible termination of the		
					employment will be a		
	The CNA was si	ispended, pending			consideration for any staff		
		d terminated on 5/27/11,			member involved in a		
	1				substantiated allegation of al	buse	
		y, for passive neglect and			toward a resident. III. What		
	gross carelessne	SS.			measures will be put into pla what systemic changes will b		
					made to ensure that the defi		
		I follow-up were reported			practice does not recur?An a		
	to ISDH (Indian	a State Department of			staff in-service will be held by		
	Health) and other	r various agencies on			7/15/2011 & conducted by th	e	
	5/27/11 per ISD	H regulations and facility			DNS/designee. This in-servi		
	protocol.	2			will include review of the faci		
	F1010201.				policy and procedure regardi	•	
	The Administrat	or was interviewed on			Abuse Prohibition, Reporting		
		or was interviewed on			Investigation. Any allegation statement regarding resident		
	6/16/11 at 10:20	a.m. to review the abuse			statement regarding resident	L	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		(X2) MU A. BUIL B. WINC		OO	(X3) DATE S COMPL 06/17/2	ETED	
	PROVIDER OR SUPPLIER		B. WINC	STREET AD	DDRESS, CITY, STATE, ZIP CODE RACY ST ., IN46770		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	the employee had according to the 3.1-27(a)(3)				abuse or mistreatment will be reported immediately to the Administrator and DNS. The facility will immediately initiat full investigation as well as ensure notification to the MD family, ISDH, and other agen as outlined in the facility polic How will the corrective action be monitored to ensure the deficient practice will not rective. what Quality Assurance Program will be put into place?The DNS or other designee will be responsible completion of the CQI Audit titled, "Abuse Prohibition and Investigation" and "Abuse" w X4, monthly X3, and then quarterly thereafter to monitor ongoing compliance. Any tree or findings will be submitted to CQI Committee for review ar follow-up. Compliance Date: 7-17-11	e a cicies cy.IV. n(s) ur, for Tool l eekly or for nds to the	
F0248 SS=D	program of activitie accordance with the assessment, the in	rovide for an ongoing es designed to meet, in ne comprehensive nterests and the physical, osocial well-being of each					
	Based on observarecord review, the activity needs resident reviewed sample of 15 (Refindings include		F02	248	F248 - Activities is the pract of this facility to provide an ongoing program of activities designed to meet the interest and the physical, mental, and psychosocial well-being of earesident. I. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? Resident #32 is	ts d ach d for e	07/17/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YIQU11

Facility ID:

000544

If continuation sheet

Page 6 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	00	COMPL	ETED
		155673	B. WIN	LDING		06/17/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIEI	₹		1	RACY ST		
MADKIE	E HEALTH & REHAI	RII ITATION		1	E, IN46770		
	- HEALITI & INCHAI	BILITATION		IVIAININ			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	_	DATE
	the following for	r June 13 through June			receiving one-on-one visits		
	15, 2011.				this is being documented or	tne	
					Individual Programming Participation Record.The ac	tivity	
	June 13: 7: 00 a.m Breakfast, 8:00 a.m.				care plan has been updated	•	
		elaxation, 10:00 a.m			resident #32.An updated ac		
	_	30 a.m Juice and coffee,			progress note has been writ	•	
	· ·	hin' up, 11:15 a.m			for resident #32.II. How will	•	
		* *			identify other residents havi		
		m Clean up and			potential to be affected by the		
	1	p.m Baking/snack, 3:00			same deficient practice and corrective action will be take		
	1 ^	, 4:00 p.m Today is,			residents are at risk to be	:II ! AII	
	4:30 p.m Fresl	nin' up, 5:00 p.m			affected by this finding.An a	udit	
	Supper, 6:00 p.n	n Reminisce			will be performed on all resid		
					to ensure that activity care p		
	June 14 · 7· 00 a	.m Breakfast, 8:00 a.m.			are present and are an accu	ırate	
		elaxation, 10:00 a.m			reflection of the resident. A		
	_	a.m Juice and coffee,			audit will also be performed		
	•				residents to ensure that acti	-	
		hin' up, 11:15 a.m			progress notes are current a present for all residents.All	ariu	
		m Clean up and			residents requiring 1 on 1 vi	sits	
	· ·	p.m Coloring, 3:00 p.m.			will be reviewed for accurac		
	- Craft, 4:00 p.m	n Devotion, 4:30 p.m			a new revised list will be		
	Freshin' up, 5:00	p.m Supper, 6:00 p.m.			generated for those residen	ts	
	- Reminisce				needing 1 on 1's.III. What		
					measures will be put into pla		
	June 15 · 7 · 00 a	.m Breakfast, 8:00 a.m.			what systemic changes will made to ensure that the def		
		elaxation, 10:00 a.m.			practice does not recur?Acti		
		:30 a.m Juice and			personnel will be re-educate		
	· · · · · · · · · · · · · · · · · · ·				1 on 1's, timeliness & compl		
	1	n Freshin' up, 11:15 a.m.			of progress notes & on time	ly	
		o.m Clean up and			completion of care plans that		
		p.m Baking and snack,			an accurate reflection of the		
	3:00 p.m Craf	t, 4:00 p.m Today is,			resident. Re-education will	be	
	4:30 p.m Fresh	nin' up, 5:00 p.m			completed by 7-15-11 & conducted by SDC/designed	ء	
	Supper, 6:00 p.n	n Reminisce			Activity personnel will keep		
					record of residents invited a		
	The following of	bservations were made of			they accepted or declined.		
	1 - 10 10 11 11 16 0						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155673	B. WIN			06/17/2011
			D. 11111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				RACY ST	
MARKLE	HEALTH & REHAE	BILITATION			E, IN46770	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	Resident # 32 in	her recliner in her room:			Memory Care Coordinator w	
	June 13, 2011: 9	2:50 a.m 10:30 a.m.,			review this record each week	
	12:00 p.m 1:00	p.m., 2:00 p.m 3:30			ensure all residents are offer the opportunity to participate	
	p.m., and 5:15 p.				How will the corrective action	
		':30 a.m 8:00 a.m., 9:30			be monitored to ensure the	
	· ·	, 12:40 p.m 1:45 p.m.			deficient practice will not reci	ur,
		:15 a.m 11:00 a.m.,			i.e. what Quality Assurance	
	· ·				Program will be put into	
	12:45 p.m 3:30	p.m.			place?Facility management	
					personnel will be responsible complete a CQI Audit Tool tit	
		vas conducted on June 13,			"Activities". Completition of t	
	2011 with LPN #	1. During the tour,			audit tool will be performed	1113
	Resident # 32 wa	as observed sitting in the			weekly x 4 weeks & then mo	nthly
	recliner in her ro	om, sleeping. The			x 3 months. CQI Committee	will
	resident's room v	vas close to the nursing			then re-evaluate the need for	-
	station and activ	•			continuation. Any trends or	.
	Station and activ	ity, anning area.			findings will be submitted to t CQI Committee for review ar	
	The eliminal room	rd of Resident # 32 was			follow-up.Compliance Date:	iu
					7-17-11	
		5/11 at 9:15 a.m. The				
		the resident's diagnoses				
	1	re not limited to, mood				
	disorder, depress	ion, and anxiety.				
	The annual Mini	mum Data Set				
	Assessment (MD	OS), dated 3/12/11,				
	`	nt # 32 required staff				
		nsfer and ambulation.				
		ted the resident enjoyed				
		ers, music, animals, the				
	· · · · · · · · · · · · · · · · · · ·	and to be with groups of				
	people.					
	The IIO #					
	_	re plan" dated 5/31/11				
		dent's family should be				
	encouraged to vi	sit, encourage				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILI		nstruction 00	(X3) DATE S COMPL		
		155673	B. WING			06/17/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE RACY ST		
MARKLE	HEALTH & REHAE	BILITATION		MARKLI	E, IN46770		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	· ·	d the resident loved cats,					
	· · · · · · · · · · · · · · · · · · ·	rsing. There was no in the clinical record.					
	activity care plan	in the chinetic record.					
		ctivity Progress notes in					
		nical record. When /16/11 at 9:30 a.m.,					
		# 2 indicated she had					
	taken the activity	notes from the clinical					
		ald make an entry. She					
	indicated Resident # 32 was in her room all week. She indicated the resident did						
		ing on 6/13/11 or to the					
	1	4/11. The activity					
		ndicated the resident did					
	not receive one to	o one visits for					
		indicated she had no					
	record of spendir	ng time with the resident.					
	There were two	entries made in the					
	Activity Progress	s notes, one dated 1/14/11					
		4/11. The notes were					
	_	7/11 at 8:30 a.m. by					
	1	# 2. She had added a					
	plan was added,						
	F,						
	3.1-33(a)						

AND PLAN	OF CORRECTION PROVIDER OR SUPPLIER HEALTH & REHAE SUMMARY S (EACH DEFICIEN REGULATORY OR	(X2) MI A. BUII B. WIN	LDING G STREET A 170 N 7	DNSTRUCTION 00 ADDRESS, CITY, STATE, ZIP COFFICE STATE STATE, ZIP COFFICE STATE ST	DDE RECTION HOULD BE	LETED	
F0253 SS=E	maintenance serva sanitary, orderly Based on observe facility failed to vents in the hally dust-free. The de 56 of 66 residen Findings include The environment 6/15/11 from 1:00 the Maintenance following observe The cold air return hall had a heavy giving the white The cold air return hall had a heavy it, giving the white appearance. The cover on the 300 accumulation of white vent a gray air return vent colleading to the Maheavy accumulation the white vent colleading to the Maheavy accumulation of white vent colleans the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the white vent colleans are supplied to the Maheavy accumulation of the Maheavy accumu	tal tour was conducted on 20 p.m. to 2:20 p.m. with Supervisor. The vations were completed: rn vent cover on the 200 accumulation of dust, vent a gray appearance. rn vent cover on the 100 accumulation of dust on	FO	253	F253 - EnvironmentIt practice of this facility housekeeping and maservices in a sanitary and comfortable inter corrective action(s) waccomplished for thos found to have been at the deficient practice? return vents in the haimmediately cleaned. How will you identify residents having the peaffected by the sarpractice and what cor action will be taken? A in the facility have the beaffected by this practice. Maintenance completed a visual auxillaway vents to detened for cleaning of a vents. All hallway vents having the personnel. III. What will be put into place of systemic changes will ensure that the deficiency does not recur? Hallway cleaning was added and cleaning Guidelines. Re-education will be by 7-15-11 & conduct Maintenance Superviwill the corrective actimonitored to ensure the corrective actimonity and corrective actimonity actions actions and corrective actimonity actions actions and corrective actions acti	or to maintain aintenances or to maintain aintenances or orderly, rior.I. What will be see residents affected by the see residents are considered by the see. IV. How ion(s) be	07/17/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155673	A. BUIL	DING	00	06/17/20	
		199079	B. WIN			00/17/20	711
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MARKLE	HEALTH & REHAB	ILITATION			E, IN46770		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG		-4	DATE
		environmental tour,			practice will not recur, i.e. wh Quality Assurance Program v		
		t covers were to be			be put into place?Maintenand		
dusted daily.				supervisor will monitor			
	3.1-19(f)				compliance by completion of	а	
	3.1-19(1)				Quality Control Inspection-Housekeeping for	m	
					Form will be completed daily		
					days, weekly x 4 and monthly		
					thereafter. After 90 days, CO		
					will re-evaluate to determine need for continuation. Trend		
					will be reported to the C.Q.I.	15	
				committee for review.Comple	etion		
					Date: 7-17-11		
F0323		nsure that the resident					
SS=E		ins as free of accident sible; and each resident					
	·	supervision and assistance					
	devices to prevent	accidents.					
	Based on observa	ation, interview, and	F0	323	F323-AccidentsIt is the pract	ice	07/17/2011
	record review, th	e facility failed to			of the facility to ensure the resident environment remain:	989	
	maintain water te	_			free of accident hazards as		
	hand-washing sir	nk in 1 of 4 resident			possible, including water		
		luring the environmental			temperatures.l. What correct		
	•	three shower rooms at a			action(s) will be accomplishe those residents found to have		
	•	below 120 degrees			been affected by the deficien		
	* /	This potentially affected			practice?The mixing valve wl	nich	
		g on the 300 hall of the			serves the 300 hall shower ro	oom	
	66 residents livin	g in the facility.			and resident room 300 was changed on 6/29/2011. The v	_{water}	
					temperatures are testing with		
	Findings include:	:			the acceptable range of 110-	120	
					degrees. II. How will you ider	ntify	
	1. The hand-was	shing sink in Room 300			other residents having the potential to be affected by the	_	
		water temperature during			same deficient practice and v		
	the environmenta	al tour conducted from			corrective action will be taker		
	1:00 to 2:20 p.m.	on $6/15/11$. The room			resident rooms and shower a	ireas	
					have the potential for being		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155673	B. WIN			06/17/2	011
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8		1	RACY ST		
MARKI F	E HEALTH & REHAE	BILITATION		1	E, IN46770		
			_	ID	1		(V.E.)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	+	d at the time. The water			affected by this		
	1	stered 128 degrees F on			finding.Maintenance personn	iel	
	1 ^	of the Maintenance			checked the water temperatu		
	Supervisor.	of the Maintenance			in all resident rooms and sho		
	Supervisor.				rooms and determined that the water temps were within norr		
	D : C4 "IT	S 1 W 4			range. Any rooms found to h		
	Review of the "I	-			water temps testing above th		
	_	orm for May 2011			acceptable range will immed	iately	
		ter temperature for Room			be evaluated for the		
		cently been checked on			cause. If a faulty mixing valve determined to be the cause,		
	I .	perature had registered			the mixing valve will immedia		
	_	n that day. The sink			be replaced with a new one.I	•	
	water in Room 3	07 was checked on			What measures will be put in		
	5/11/11 and regis	stered a temperature of			place or what systemic chan	-	
	117 degrees F.				will be made to ensure that the	ne	
					deficient practice does not recur?Maintenance personne	النبداد	
	The Maintenance	e Supervisor indicated,			re-educate staff about report		
		on the environmental			water temperatures which	9	
	_	Room on the 300 hall			fluctuate or seem to be eleva	ited.	
	1	307 were all on the same			Re-education will be complet	ed	
		m the water heater			by 7-15-11. Maintenance personnel will take & record to	the	
	serving the 300 l				water temperatures for all	ii iC	
	Serving the 300 i	iuii.			resident rooms & shower		
	2 The chower w	vater temperature in the			areas 2X each weekday x 4		
		room was also checked			weeks and then 1X each		
		onmental tour. The water			weekday x 4 weeks to ensure compliance. Thereafter, wat		
	~				temperatures, throughout	eı	
	registered a temp	perature of 128 degrees F.			the resident care areas, will be	oe	
	mi i	,			taken and recorded 1 x each		
		n was not included on the			weekday, with rooms being		
	1	mperature" form. During			randomly selected. This randomly selected a minimum		
	the interview on the environmental tour,				selection will include a minim of 3 resident care areas on e		
		Supervisor indicated this			hallway. All rooms will be tes		
	was because CN	As assisted residents with			no less than monthly.		
	showers and wor	uld adjust the water			Temperatures will be recorde		
	temperature as n	ecessary.			the Daily Water Temperature	s	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII		00	COMPL	ETED	
		155673	B. WIN	G		06/17/2	011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 170 N TRACY ST MARKLE, IN46770				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0371 SS=E	considered satisfa local authorities; a	distribute and serve food			Log. Any elevated temperatifound will be immediately reported to maintenance personnel & corrected. IV. Hwill the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. who Quality Assurance Program who be put into place? Maintenance director or other designee with responsible for completion of a CQI Audit Tool titled "Facilient Enrironmental Review" week a months & monthly thereafted monitor for ongoing compliar Any trends or findings will be submitted to the CQI Commit for review and follow-up. Compliance Date: 7-17-11	How e cient nat will ce II be f ty, ser to nce.	
	Based on observative record review, the sanitary cond and window blind service areas of the facility failed thickened liquids while passing methe Food Pantry, to ensure an expiralso failed to ensure popcorn popper with the sanitary of the facility failed to ensure an expiral so failed to ensure and expiral so failed	ation, interview, and e facility failed to ensure ition of the vents, lights ds in the food prep and he kitchen. In addition, to ensure 2 of 2 boxes of s, used by nursing staff edications, and stored in were dated after opening ration date. The facility ure the professional was kept clean for 43 of g the common area	F0	371	F371 - Sanitary ConditionsIt practice of this facility to store prepare, distribute, and serve food under sanitary condition. What corrective action(s) will accomplished for those resid found to have been affected the deficient practice? The cevents, lights and window blin the food prep & service areas the kitchen have been cleaned Both boxes of thickened liquit the Food Pantry were discard The professional popcorn powas cleaned. The portable table/tv tray was cleaned. II. will you identify other resident	e, e ns.I. l be lents by silling ds in s of ed. ids in ded. pper	07/17/2011

Facility ID:

I ′			(X2) M	ULTIPLE CC	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155673	B. WIN	IG		06/17/2011	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDEN ON SOLVER			1	TRACY ST		
MARKLE	HEALTH & REHAB	SILITATION		MARKL	.E, IN46770		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	1	The facility also failed to			having the potential to be aff		
	ensure the cleanl	iness of a portable table			by the same deficient practice and what corrective action w		
	used for dining b	y 1 of 23 residents			taken?All vents, lights and		
	observed at meal	time on the secured unit.			window blinds & portable tab	les	
	(Resident # 43).				have the potential to affected	l by	
					this same deficient practice.	• • • • • • • • • • • • • • • • • • •	
	Findings include:				vents, ceiling lights, and wind		
					blinds have all been added to dietary Monthly Cleaning	o the	
	 1 Δ The dietary	sanitation tour was			Schedule. Residents no long	er	
	_ -				use the portable table/tv tray	•	
	completed on 6/16/11 at 10:00 a.m. with the dietary manager (DM). Four steel, round, ceiling vents were observed over the food prep and service areas. All four				it has been removed from the	• • • • • • • • • • • • • • • • • • •	
					cottage. All boxes of thicken		
					liquid were checked for expir		
					dates and discarded if indica Dietary is now attaching a la		
		have brown stain			the unopened boxes of thick	• • • • • • • • • • • • • • • • • • •	
	covering them.				liquid & the person opening t	• • • • • • • • • • • • • • • • • • •	
					box will document the date		
	The DM was inte	erviewed and the cleaning			opened on this label.III. Wha	l l	
	schedule reviewe	ed on 6/16/11 at 10:30			measures will be put into pla	• • • • • • • • • • • • • • • • • • •	
	a.m. The DM inc	dicated the ceiling vents			what systemic changes will to made to ensure that the deficient		
	were not include	ed on the cleaning the			practice does not recur?Diet	• • • • • • • • • • • • • • • • • • •	
	cleaning schedule	e so she did not know			staff will be re-educated on	´	
	when they were l				sanitation including cleaning	• • • • • • • • • • • • • • • • • • •	
					vents, ceiling lights and wind	l l	
	1. B. There were	ten, boxed, rectangular			blinds. Re-education will tak place by 7-15-11 & conducte	• • • • • • • • • • • • • • • • • • •	
		he kitchen ceiling. The			the facility dietician. Nursing	- I	
	~	e			will be re-educated regarding		
	outside rims of all ten were covered with brown splotchy stains.				need to place a date on the		
	orown spiciony s	ums.			thickened liquid when openir	• .	
	The DM	unviorated and the election			a new box. Re-education wi	li be	
		erviewed and the cleaning			conducted by SDC prior to 7-15-11. Dietary will check to	ne	
		ed on 6/16/11 at 10:30			nurses pantry on a daily bas		
		dicated the ceiling lights			check for the presence of a	• • • • • • • • • • • • • • • • • • •	
	were not included	· ·			on the opened boxes of thick	rened	
		did not know when they			liquid and immediately disca		
	were last cleaned				any items found to be undate	ed.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155673	A. BUI	LDING	00 COMPLETED 06/17/2011		
		155075	B. WIN			00/17/2	011
NAME OF I	PROVIDER OR SUPPLIER	Ł		1	ADDRESS, CITY, STATE, ZIP CODE		
		NU ITATIONI		1	RACY ST		
MARKLE	HEALTH & REHAE	BILITATION		MARKL	E, IN46770		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	1. C. A large verbelow the handwithe vent was covered a.m. The wall verbelow the cleaning schedule reviewed a.m. The wall verbelow to remove to the cleaning schedule to remove to the cleaning schedule to remove to the cleaning schedule reviewed a.m. The window included on the control of the			I	Dietary will initial a log each of time they check the pantry for items. Activities staff will inspirate professional popcorn popularly for any cleaning need. Activities staff will clean inside outside the machine immedia after each use & document of "Popcorn Machine Cleaning/Inspection Log". IV. How will the corrective action be monitored to ensure the deficient practice will not receive. What Quality Assurance Program will be put into place? Dietician will monitor compliance of monthly clean the vents, ceiling lights and window blinds & for the pressof undated/expired thickened liquid in the nurses pantry duher routine visits to the facilit Monitoring will be done 2 x monthly & documented on the Safety and Sanitation Review form. A copy of this documentation will be provided to the facility Administrator and dietary manager & also will be review during the monthly QCI meetings. Maintenance/Houseping Supervisor will monitor the popcorn popper for compliance with cleanliness during random spot checks.	day or ect oper le & ately on the ing of ence l uring y. e	
					Maintenance will document results on a CQI audit tool wax 4 and monthly x 2. After 9	•	
					days, CQI committee will re-evaluate to determine the for continuation.Trends will b		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15673 NAME OF PROVIDER OR SUPPLER MARKLE HEALTH & REHABILITATION OX-9 ID PREFIX CACH DEFICIENCY MIST BE PERCEDED BY FULL TAG 2. The Food Pantry was observed during the environmental tour on 6/15/11 from 1:00 p.m. to 2:20 p.m. Two of 2 boxes of thickened liquid were dated on 6/2/11 with permanent marker. The labels printed on both boxes indicated the liquids should be used "within 5 days of opening." No other dates were on the box. The Administrator indicated, on 6/17/11 at 9:30 a.m., that she had interviewed a nurse and the boxes had both been opened on 6/15/11. She also indicated the marked date on the boxes had been put there when the thickened liquids had been deflivered to the kitchen by the supplier. There was no indication on the box as to when the boxes were opened, only the marked date of delivery; therefore, there was no way to know when the drinks expired. 3. The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. The common Activity Room, located on the 200 hallway, was observed to have a professional popcorn popper with glass doors. The popping box had kernels of popped corn still in it. There was also a crusty sticky residue on the top of the popping box. Here was salt and popcorn	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION (X4) ID PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 2. The Food Pantry was observed during the environmental tour on 6/15/11 from 1:00 p.m. to 2:20 p.m. The Administrator indicated, on 6/17/11 at 9:30 a.m., that she had interviewed a nurse and the boxes had both been opened on 6/15/11. She also indicated the marked date on the boxes had been delivered to the kitchen by the supplier. There was no indication on the box as to when the boxes were opened, only the marked date of delivery; therefore, there was no way to know when the drinks expired. 3. The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. The common Activity Room, located on the 200 hallway, was observed to have a professional popcorn popper with glass doors. The popping box had kernels of popped corn still in it. There was also a crusty sticky residue on the top of the	AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:		, DI III	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER MARKLE, HEALTH & REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES PRETIX (EACH DEFICIENCY MIST BE PERCEDED BY FULL TAG 2. The Food Pantry was observed during the environmental tour on 6/15/11 from 1:00 p.m. to 2:20 p.m. Two of 2 boxes of thickened liquid were dated on 6/2/11 with permanent marker. The labels printed on both boxes indicated the liquids should be used "within 5 days of opening." No other dates were on the box. The Administrator indicated, on 6/17/11 at 9:30 a.m., that she had interviewed a nurse and the boxes had both been opened on 6/15/11. She also indicated the marked date on the kirchen by the supplier. There was no indication on the box as to when the boxes were opened, only the marked date of delivery; therefore, there was no way to know when the drinks expired. 3. The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. The common Activity Room, located on the 200 hallway, was observed to have a professional popcorn popper with glass doors. The popping box had kernels of popped corn still in it. There was also a crusty sticky residue on the top of the			155673	1			06/17/2011	
MARKLE HEALTH & REHABILITATION CAYID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG 2. The Food Pantry was observed during the environmental tour on 6/15/11 from 1:00 p.m. to 2:20 p.m. The Administrator indicated, on 6/17/11 at 9:30 a.m., that she had interviewed a nurse and the boxes had both been opened on 6/15/11. She also indicated the marked date on the tickened liquids had been delivered to the kitchen by the supplier. There was no indication on the box as to when the boxes were opened, only the marked date of delivery; therefore, there was no way to know when the drinks expired. 3. The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. The common Activity Room, located on the 200 hallway, was observed to have a professional popoern popper with glass doors. The popping box had kernels of popped corn still in it. There was also a crusty sticky residue on the top of the				B. WIIV		ADDRESS CITY STATE ZIP CODE		
MARKLE HEALTH & REHABILITATION MARKLE, IN46770	NAME OF I	PROVIDER OR SUPPLIEF	8					
OX-10 DEPARTMENT OF DEFICIENCIES ID PROPERTY PR	MARKIE	ΗΕΔΙΤΗ & REHΔΕ	RII ITATION		1			
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reported to the CQI committee for follow-up. Compliance Date: 2. The Food Pantry was observed during the environmental tour on 6/15/11 from 1:00 p.m. to 2:20 p.m. Two of 2 boxes of thickened liquid were dated on 6/2/11 with permanent marker. The labels printed on both boxes indicated the liquids should be used "within 5 days of opening." No other dates were on the box. The Administrator indicated, on 6/17/11 at 9:30 a.m., that she had interviewed a nurse and the boxes had both been opened on 6/15/11. She also indicated the marked date on the boxes had been put there when the thickened liquids had been delivered to the kitchen by the supplier. There was no indication on the box as to when the boxes were opened, only the marked date of delivery; therefore, there was no way to know when the drinks expired. 3. The environmental tour was conducted on 6/15/11 from 1:00 p.m. to 2:20 p.m. The common Activity Room, located on the 200 hallway, was observed to have a professional popcorn popper with glass doors. The popping box had kernels of popped com still in it. There was also a crusty sticky residue on the top of the		`				CROSS-REFERENCED TO THE APPROPRIATE	ΓE	
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TV lounge area of the Cottage adjacent to the dining area. The Activity Director pushed a small white portable table up to the resident and served her dinner plate of green beans, mashed potatoes, and		At 5:35 p.m., Ac	tivity Director # 2					
the dining area. The Activity Director pushed a small white portable table up to the resident and served her dinner plate of green beans, mashed potatoes, and		assisted Resident	t # 43 into a chair in the					
the dining area. The Activity Director pushed a small white portable table up to the resident and served her dinner plate of green beans, mashed potatoes, and		TV lounge area o	of the Cottage adjacent to					
pushed a small white portable table up to the resident and served her dinner plate of green beans, mashed potatoes, and		-						
the resident and served her dinner plate of green beans, mashed potatoes, and		_	•					
green beans, mashed potatoes, and		•						
			_					
		-	-					
with bread and butter, a small plate with a		-						
cookie, and glasses of milk, iced tea, and			_					
red punch on top of the tray. The tray was								
observed to have black and brown food			-					
substance along the edge of the table								
closest to the resident.			•					
		2103031 10 110 103.						
Resident # 43 began to eat her green		Resident # 43 be	gan to eat her green					
beans and Salisbury steak with her		beans and Salisb	ury steak with her					
fingers. She picked up green beans, and		fingers. She pick	ked up green beans, and					
ran her fingers along the edge of the table		-						
where the food substance was stuck to the		_	_					
table. The resident then put the food into		table. The reside	ent then put the food into					

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l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED (2011
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION		170 N T	ADDRESS, CITY, STATE, ZIP C FRACY ST E, IN46770	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	red punch on the observed from 5 Staff were not ob assist the resident On 6/15/11 at 9:0 # 1 pulled the will the TV lounge. Indicated the tab stained, went to rag, and scrubbe interviewed, on Activity Director food substance stable was from the aten two days pure The Housekeepe 6/15/11 at 1:05 p.	resident spilled a glass of table. The resident was a 35 p.m. to 6:00 p.m. oserved to intervene or to at during the meal. 200 a.m., Activity Director interportable table from The Activity Director le was very dirty and the kitchen area for a wet did the table clean. When 6/15/11 at 9:05 a.m., the rindicated the brown till on the side of the ine chocolate cupcakes rior on 6/13/11. The housekeeper mot her job to wash the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155673		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/2	ETED	
	PROVIDER OR SUPPLIER HEALTH & REHAE			170 N T	DDRESS, CITY, STATE, ZIP CODE RACY ST E, IN46770		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0514 SS=D	each resident in a professional stand complete; accurat accessible; and sy. The clinical record information to ider the resident's asseand services provipreadmission screes tate; and progrees Based on intervious facility failed to physician rewrite the physician's siresidents medical sample of 15 (Reference of the clinical record indicated included, but we anemia, heart discontinue) Agency (discontinue) Agency (Chloride, D/C LD/C Vitamin, D.	ew and record review, the ensure the June 2011 es were correct prior to gnature for 1 of 15 tion orders reviewed in a esident # 37).	F0:	514	F514- Clinical RecordsIt is the practice of this provider to maintain accurate, complete organized clinical information about each resident that is reaccesible for resident care. I. What corrective action(s) will accomplished for those reside found to have been affected the deficient practice? Reside #37 experienced no negative outcome as a result of this finding. Resident #37 clinical record has been corrected an accurately reflects this reside current medications. The physician was made aware of error on the June Physician Rewrites. II. How will you identifier to be affected by the same deficient practice and corrective action will be taken residents are at risk to be affected by this finding and windentified through a facility at This audit will include a revie all resident charts to ensure	and	07/17/2011

i ´			(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING 00			COMPLETED	
		155673	B. WIN			06/17/2	011	
			B. ((1))		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R			RACY ST			
MARKLE	HEALTH & REHAE	BILITATION		1	E, IN46770			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		_	<u> </u>	,		(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	DATE			
-		5/11, indicated, "	1	-	physician orders have been			
		0 mg (milligrams), Pot			accurately transcribed and			
	00	C \ C //			accurately noted on the mos	t		
	,	ium Chloride) 10 meq			recent Physician Rewrite. Ar			
	l ` • • · · ·	Lisinopril 2.5 mg,			discrepancies will be correct			
	·	, High Potency Vits			and clarified when identified.			
	(vitamins) & Mi	nerals, Ferrous Sulf			Nurse Management Team is			
	(sulfate) 220 mg				responsible for completion or audit. In addition, the Nurse	i ii ii 5		
					Management Team is respor	nsible		
	The June 2011 N	Medication Administration			for daily review of all Physici			
		was reviewed. The			Orders. This review includes			
	medication were				checking that all orders have	•		
		~ ~			been accurately transcribed			
	discontinued on	6/1/11.			onto the MAR/TAR and onto	the		
					current Physician Rewrite Orders.III. What measures w	مط الن		
	LPN # 1 was into	erviewed on 6/16/11 at			put into place or what systen			
	8:40 a.m. The n	urse indicated the			changes will be made to ens			
	medications wer	e discontinued by the			that the deficient practice do			
	physician on his	5/31/11 visit. She			not recur?An all nursing staf			
		dications should have			in-service will be held by			
		e June rewrites before the			7/15/2011 & conducted by th			
		current on 6/5/11.			DNS/designee. This in-service			
	doctor signed as	current on 6/3/11.			will include review of the faci	lity		
					process for physician order transcription, including update	tes to		
	3.1-50(a)(2)				the current Physician Rewrite			
					accurately reflect each reside			
					current medication list and			
					physician orders. This in-ser	vice		
					will also include review of the			
					facility monthly Rewrite proce			
					ensure all physician's orders	are		
					accurately transcribed and correctly noted on each mon	thly		
					Rewrite.IV. How will the corr			
					action(s) be monitored to en			
					the deficient practice will not			
					recur, i.e. what Quality Assu			
					Program will be put into			
					place?The DNS and/or design	gnee		

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AND PLAN OF CO		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155673	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 06/17/2	LETED
NAME OF PROVIDER OR SUPPLIER MARKLE HEALTH & REHABILITATION			170 N	ADDRESS, CITY, STATE, ZIP C FRACY ST LE, IN46770	CODE	
	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
				will be responsible for of the CQI Tool titled Condition Report Rex 4 and then monthly ensure ongoing comfindings will be submic CQI Committee for refollow-up.Compliant 7-17-11	or completion d, "24 Hour eview" weekly y thereafter to apliance. Any nitted to the review and	